The Consumer Choice Medicaid Reform Plan: Redesigning Medicaid for the Future

March 10, 2008

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Problem Statement

Without immediate change, the Rhode Island Medicaid program is projected to grow at a rate of approximately 7% per year through 2013. As this rate of expenditure growth is unsustainable, decision-makers face difficult choices regarding reductions in eligibility, benefits, or rates. Over half of each new tax dollar generated in Rhode Island is going into the Medicaid program. Medicaid is the number one expenditure in Rhode Island.

The state faces a budget shortfall of $384 million in state fiscal year 2009. In addition, the State of Rhode Island has for a number of years been involved in a variety of strategies to improve the quality of services, allow for more choices, rebalance the service delivery system, and manage care. Even with all of these programs, waivers and system re-designs, the state of Rhode Island has not been able to fully reform its Medicaid program to focus on competition, prevention, wellness, personal responsibility, choice, consumer empowerment and independence. Consequently, today the emphasis in the program remains on meeting the needs of the providers and not the person.

- The Medicaid system has become centered on everyone but the person.
- Medicaid recipients have limited choices over the services they receive;
- The long term care of the vast majority of low-income seniors is primarily provided in institutionalized care/nursing homes, at high cost, rather than in community-based settings where care can often be provided at less cost, and with a greater quality of life
- The program does not reward prevention, wellness and disease management;
- Medicaid payments are not linked to quality and performance;
- The information technology that supports Medicaid is not easily transparent and accessible to consumers and providers prior to making important decisions regarding health and wellness;
- Too many children receiving services are in high-cost residential care and/or group homes, and often in out-of-state placements, rather than remaining in their communities;
- Services for individuals with behavioral health care needs are fragmented and do not treat the person as a whole nor the whole family. Services need to treat the substance abuse and/or mental health needs at the same time as recognizing the impact of medical, housing and employment needs.
- The deinstitutionalization of the delivery system for individuals with developmental disabilities has not progressed beyond the group home level. Services need to support the ability of individuals and families to make life-long decisions about supports in the community.
- We need to offer incentives to providers to develop new family level services and to build new areas of capacity.
- There is no meaningful competition among providers
- Personal responsibility over a number of health-related decisions is lacking

Guiding Principles for Medicaid Reform:

- **Consumer Empowerment and Choice**. If consumers have more information about and control over their health care services, they will make healthier and more cost-effective choices and that their good decision-making could be rewarded.

- **Personal Responsibility**. Consumers, armed with good medical information, in some cases a fiscal intermediary, and adequate access to needed services, can become better shoppers of health care for themselves and their families. Ultimately, improved technology will play a strong role in measuring the impact of this approach. Health Savings Accounts can be used to drive personal responsibility, choice and empowerment.

- **Community-based care solutions**. Rhode Island is committed to moving people from institutions to the community and to helping more people remain in the community, as they require long-term care or child residential services. Rhode Island's program re-design is based on the assumption that community based care services will result in improved health, quality of life and more cost-effective care.

- **Prevention, Wellness and Independence**. Encourage consumers to receive individualized health care that is focused on prevention, recovery and independence and that such care will result in improved health outcomes.

- **Competition.** Competition between health care providers will result in improved care and reduce inflation trends.

- **Pay for Performance**. Quality of care will improve if reimbursement to physicians, dentists, hospitals, and other major providers is tied to common, evidence-base quality performance measures, including patient satisfaction and information technology investments.

- **Improved Technology as a key ingredient** The current technology must be revamped to guide decision makers, consumers and providers to make informed and cost-effective decisions regarding health care.

Rebalancing the Long Term Care System and De-Institutionalization across the Spectrum

Rhode Island's long-term care system is heavily based on nursing home care, residential care and high-end services. Through this change initiative, the State of Rhode Island proposes a series of specific initiatives designed to rebalance the system in favor of community-based care by diverting prospective admissions and developing alternatives. According to the AARP 99% of the elderly want to stay in their communities. It is the intent of this proposal to provide them with that opportunity.

The Goal is to have a 50/50 split in the number of people being served between residential high-end placements and the community by 2013. There are about 40 states that already have achieved this or are close to a 50/50 split. We will accomplish this without compromising the health and safety of our beneficiaries.

The Medicaid Reform plan proposes to replace the current single level of care definition with a three-tier level of care determination process. To replace the current single level of care determination, Rhode Island will draw on elements from the successful long term care plans of other states and will create multiple levels of care.

- The highest level of care will be for nursing home and residential treatment facilities. The population with a high need will also have the option of community-based services and if they choose to receive services in the community, they will be eligible for an extensive menu of services and supports.
- A mid level of care will allow access to a broad array of community based services
- A low level of care that will provide limited benefits and which can be provided for the purpose of discharging individuals to their homes instead of nursing facilities who are in need of such services such as homemaker services or home modifications.

Financial requirements will also be modified to reduce the biases on institutional placements by:

- Applying the same financial criteria across programs and populations
- Allowing for an income disregard for living expenses. The current allowance of $692 is not high to reflect actual living expenses to allow people to remain in the community. This disregard will only be available for individuals in need of the mid level of care. In addition to the $692 this disregard will allow for a $100 disregard for electric, $100 for heat and $200 for rent/mortgage payment, thus allowing individuals to keep about $1092 a month.

The provider capacity will be enhanced in order to provide additional choices by:

- Developing share living alternatives
- Developing a medication management program
- Increase adult day care rates that are tied to performance such as increase capacity.
- Increasing assisted living slots by reducing nursing home beds and having the market adapt to the reduction
- Using Perry Sullivan monies to provide rate increases based on performance such as capacity requirements and acuity
- Expand the use of vouchers and the cash and counseling program

Medicaid beneficiaries (both new and existing beneficiaries) who may require either residential services (nursing home/ group homes/ child residential) or community support services will be referred to an Assessment Coordination Unit within OHHS. This unit will consist of both state workers (for those cases currently managed by state workers) and contractors (for those cases currently managed by contractors), and it will serve as an integral part of OHHS. The

establishment of the assessment unit will provide a clear delineation between the functions of those who assess and develop a service/treatment plan and the functions of those who are reimbursed for the delivery of services through the implementation of the plan.

The Assessment Coordination Unit will be responsible for:

- Assessments
- Development of Treatment/Service Plans
- Pricing a service budget and developing a voucher for appropriate populations
- Referral to appropriate settings
- Maintaining a brokerage component that will: train and educate consumers, discharge planners and providers; track utilization; monitor outcomes; certify providers; and review service/care plan changes
- High cost case reviews.

State staff will also be available within hospitals to assist in appropriate discharges and to insure that people are provided choice in their care setting. Additionally, state workers will be available in residential care settings to work with residents and family members to transition residents back to the community if they choose this alternative and it is appropriate.

Beneficiaries will be provided the information necessary to make informed choices. Information about prices, utilization and quality will be provided so that transparency exists. Additionally, beneficiaries will be provided report cards so they can see how much they have spent and what outcomes have been achieved.

All of these efforts will reduce the reliance on institutional placements and give Rhode Islanders choices as to where they wish to receive services.

Rebalancing the LTC System:		**General Revenue**	**Total Funds**
DCYF Program Re-design	DCYF	$3,509,512	$7,399,351
Excell Program - short term stays in RITSY	DCYF	$1,474,391	$1,474,391
Mental Health least restrictive settings	MHRH	$500,000	$1,054,185
DD Vouchers and Shared Living Increase	MHRH	$10,500,000	$22,137,887
Nursing Home Transition and Diversion	DHS	$18,000,000	$37,950,664
Rebalancing Sub-total		**$33,983,903**	**$70,016,478**

Managing Care: Medicaid beneficiaries will have a medical home.

Individuals will mandatory enroll in a managed care delivery system and have an option to enroll in a managed care plan or in a primary case management plan. Every Medicaid beneficiary will have a medical home and will have access to services that are design to meet their needs, are based on quality and performance measures.

The Plan will ensure that each person has access to appropriate services, a medical home, and support in coordinating, managing and navigating services. It will ensure personal responsibility and that individual's participation in decisions about their care.

The Plan will encourage new provider markets and create incentives for innovation and broadened care options within the continuum of care. It will promote diversion to less restrictive, appropriate settings; create incentives for cost-conscious healthy choices; promote and reward independence, personal accountability, health and wellness. There will be ongoing monitoring of performance and quality; performance base payment incentives; and cost containment through competitive based purchasing.

Included are proposals that would implement co-payments for certain services and increase premium responsibility for beneficiaries. Efforts to enhance fair share contributions from employers of public health beneficiaries are proposed.

These initiatives build on, re-engineer and expand upon long established and newly developed program options, including RIte Care, Connect Care Choice and Rhody Health Partners. In combination, these initiatives help fulfill the commitment for cost effective, person centered care management is in place for all Medicaid beneficiaries

Managing Care:		**General Revenue**	**Total Funds**
Consumer Directed Health Care - Report Cards	DHS	$3,033,306	$6,395,332
Redesigned/Reduced Benefit Package for Parents	DHS	$1,084,000	$2,285,473
Premium Accountability	DHS	$515,000	$1,085,811
Katie Beckett Power Accounts	DHS	$1,701,000	$3,586,338
Mandatory Enrollment Children Special Needs	DHS	$1,250,000	$2,635,463
Fair Share - Employer Sponsored Insurance	DHS	$1,557,000	$3,282,732
Competitive/Selective Contracting & Single Entity Accountability for Children's Behavioral Health	DHS	$9,403,000	$19,825,005
Reduce Manage Care Admin Costs	DHS	$3,135,000	$6,609,741
Mandatory Care Management for Adults	DHS	$1,300,000	$2,740,881
Primary Care Management for Adults	DHS	$3,500,000	$7,379,296
Managing Care Sub-total	DHS	**$26,478,306**	**$55,826,072**

Smart Purchasing

The current system does not promote competition and the State is paying a wide range of rates for basically the same level of care. Smart purchasing will not only allow for one consistent rate but it will also be tied to quality performance outcomes insuring that the taxpayer are getting the most effective and efficient use of their dollar.

We will institute selective contracting to purchase psychiatric inpatient beds and out patient non-urgent services at the best possible rate. This is one of the major selective purchasing initiatives in the Reform package.

Currently the State uses state-only dollars to purchase psychiatric in-patient care for uninsured individuals. This is an expensive system, which creates a fragmented network for insured and uninsured individuals. The selective purchasing of Medicaid psychiatric in-patient beds intends to fold the uninsured into this purchase. This will allow for a substantial saving and, more importantly, provide one comprehensive system of care with unified outcomes rather than a two or three-tiered system. This divided system exist because we purchase Medicaid beds and uninsured beds through two different systems and two Departments and the third level is based upon private insurance. A portion of the savings will be reinvested in community-based care since the acuity level for many of these individuals allows for a mid-level care placement.

Selective purchasing will promote competition, value and performance. At the same time, selective purchasing will continue to allow for consumer choice and personal responsibility since any hospital licensed to provide in-patient psychiatric services or entity that can provide out patient surgical services will be eligible to participate in the purchased network at the best rate. Other areas of selective contracting will be initiated if it is determined to be appropriate, cost effective and can maintain quality.

Smart Purchasing:		**General Revenue**	**Total Funds**
Competitive/selective contracting - state only InPat Psychiatric Beds	MHRH	$1,500,000	$1,500,000
Competitive/selective contracting - InPat Psychiatric Beds	DHS	$3,000,000	$6,325,111
Competitive/selective contracting – Outpatient non urgent surgery	DHS	$350,000	$737,930
Bradley Step Down Rate Reduction	DCYF	$175,000	$368,965
Best price dispensing fee	DHS	$500,000	$1,054,185
Mental Health PDL	DHS	$500,000	$1,054,185
Hospital Pharmacy Rebates	DHS	$150,000	$316,256
Smart Purchasing Sub-total		**$6,175,000**	**$11,356,631**

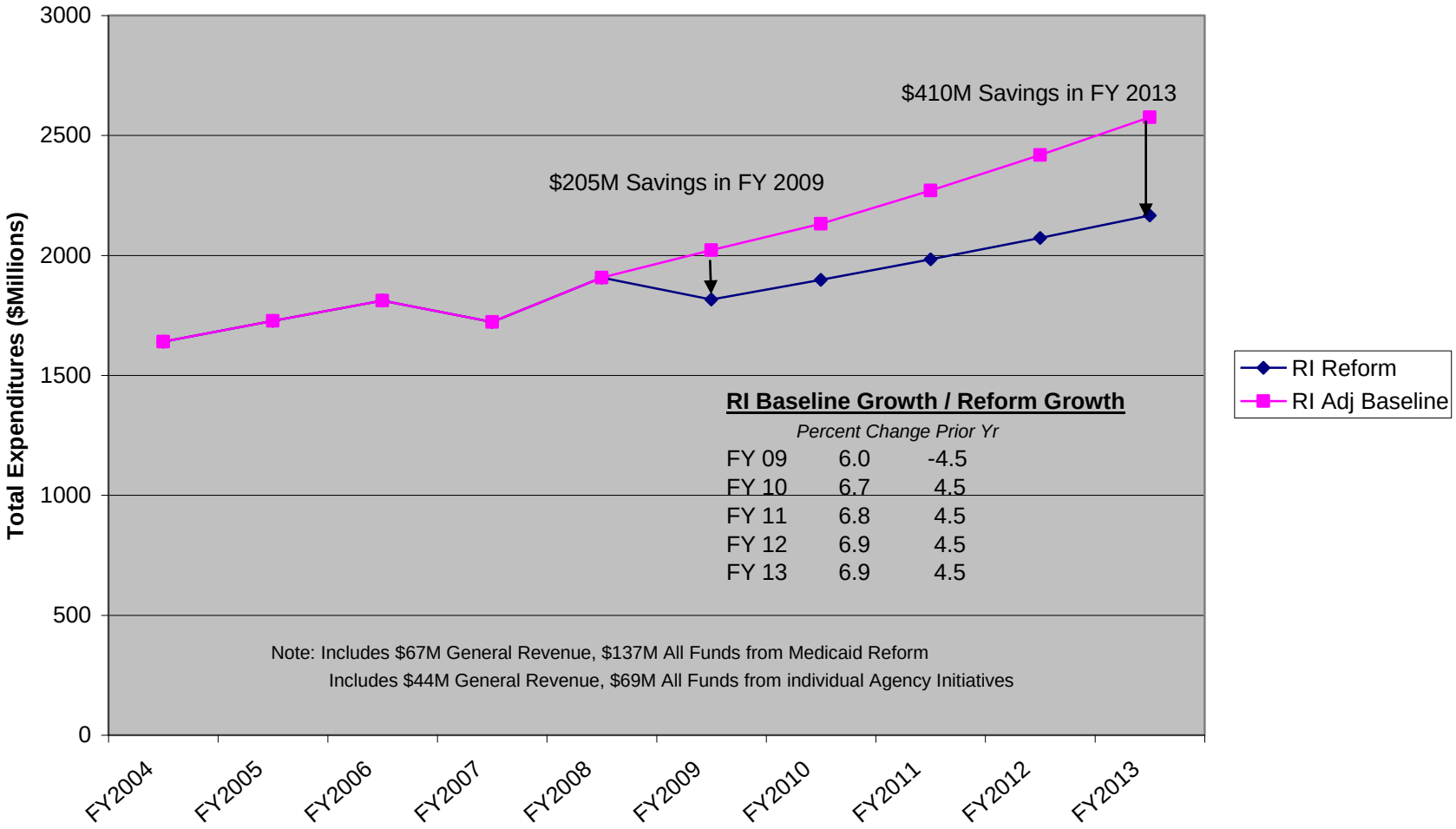
The Rhode Island Medicaid Waiver Request

Rhode Island proposes to submit a waiver to CMS that will include at least two Section 1115 Medicaid Waiver Requests and appropriate state plan amendments that will allow it to fundamentally restructure its Medicaid Program. Rhode Island is seeking waivers that will allow Rhode Island to use federal Medicaid funds to finance a broad array of community support services, administrative supports and provide incentives to beneficiaries who practice "healthy life behaviors".

The waiver will give the state the flexibility to restructure it benefit package, increase cost sharing and setting up waiting lists for additional non-traditional Medicaid services. Rhode Island will be seeking the following from the Federal Government:

❖ A trend inflator
❖ Request additional funding for the federal share of the Assessment Unit's Broker Contract and other administrative cost
❖ Request 90% match for IT costs
❖ Request waiver of comparability
❖ Request waiver of state wideness
❖ Request waiver of freedom of choice
❖ Request income and resource disregards for selected populations
❖ Request to have a differential level of care
❖ Request state be designated a Medicare Advantage Plan, or a Medicare Part D Plan, or at least pay for their share of the PCCM
❖ Request to cover children placed at the RI Training school residing in the community
❖ Request cost sharing regulation relief
❖ Request funding for a coordinator of chores services provided by faith based organizations
❖ Selective contracting
❖ Request to waive retroactivity
❖ Request waiver to go above 5% of income aggregate cap for premiums and co-pays
❖ Request ability to provide incentives/payments to beneficiaries who comply with healthy behaviors (Health Savings Account)

Rhode Island Medicaid Reform
All Funds All Agencies



Rhode Island Medicaid Reform
FY 2009 General Revenue Savings
$66.7M